

CDC Emerging Infection Program: Physician Survey

Thank you for participating in this survey of physicians. Your responses will help determine estimates of diarrheal disease in the United States. The survey will take approximately **FIVE to TEN MINUTES** to complete.

SECTION A Background information

1. What is today's date? (mo/day/yr) _____/_____/_____
2. Is your practice located in [\[sites to fill in catchment area\]](#)?
☐ yes **[continue questionnaire]**
☐ no **[stop here and return questionnaire in enclosed envelope; receiving your questionnaire is important for data analysis]**
3. On average, are you involved in direct patient care at least 8 hours a week?
☐ yes **[continue questionnaire]**
☐ no **[stop here and return questionnaire in enclosed envelope; receiving your questionnaire is important for data analysis]**
4. Which of the following describe(s) your practice? **[CHECK ALL THAT APPLY]**
☐ General Internal Medicine
☐ Subspecialty Internal Medicine
(specify _____)
☐ General Pediatrics
☐ Subspecialty Pediatrics
(specify _____)
☐ Family Practice
☐ Emergency Department practice
☐ Obstetrics/Gynecology
☐ Other (specify _____)
5. Are you currently an intern, resident, or fellow in a training program? ☐ yes ☐ no
6. What is the **PRIMARY** setting of your practice? **[CHECK ONLY ONE]**
☐ Outpatient private practice/fee for service ☐ Outpatient HMO/Managed care ☐ Hospital-based
☐ Other _____
7. In the past 12 months, have you seen **ANY** patients with an **acute diarrheal illness**? (For the purpose of this questionnaire, we define an acute diarrheal illness as ≥ 3 loose stools in a 24 hour period which had lasted < 7 days in duration before presentation).
☐ yes **[continue questionnaire]**
☐ no **[stop here and return questionnaire in enclosed envelope; receiving your questionnaire is important for data analysis]**
8. Approximately what percentage of all the patients that you see in your practice are HIV-infected?..... %
9. Approximately what percentage of all the patients that you see are referred to you from another physician?..... %
10. In the past 7 days, approximately how many different **outpatients**, including ER patients, did you see?..... **outpatients**
Of those outpatients, how many had an acute diarrheal illness? (Please don't include patients with an acute exacerbation of inflammatory bowel disease.) **outpatients**
Of those outpatients with an acute diarrheal illness, how many were subsequently hospitalized because of the acute diarrheal illness?..... **outpatients**
11. In the past 7 days, approximately how many different **inpatients** did you make rounds on or see as the primary provider or in consultation?..... **inpatients**
Of those inpatients, how many were hospitalized because of an acute diarrheal illness? (Please don't include patients with an acute exacerbation of inflammatory bowel disease.)..... **inpatients**

SECTION B Last patient with diarrhea

12. When did you see your most recent patient who had an acute diarrheal illness?
☐ ≤ 1 month ago ☐ >1 to ≤ 6 months ago ☐ > 6 months to ≤ 12 months ago

13. Regarding the last patient you saw with an acute diarrheal illness, please answer **YES**, **NO**, or **DON'T KNOW** for each question.

a. Was this patient referred to you from another health care provider specifically for the evaluation or treatment of this diarrheal illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
b. Did this patient have a temperature >101 ° F ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
c. Did this patient have bloody diarrhea ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
d. Did this patient have abdominal pain ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
e. Did this patient require intravenous rehydration ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
f. Did this patient have AIDS ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
g. Was this patient known to be part of an outbreak of diarrheal illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
h. Was this patient in a developing country in the week before diarrhea onset?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
i. Did this patient have any medical insurance , including Medicare or Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
j. Did this patient have diarrhea that lasted > 3 days ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
k. Did you refer this patient to another physician for the evaluation or treatment of this diarrheal illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
l. Was this patient an outpatient ? [IF YES] Was this patient subsequently hospitalized for this diarrheal illness?	<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know </div> </div>
m. Did you order a bacterial stool culture (other than <i>Clostridium difficile</i> testing) from this patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
n. Did someone else order a bacterial stool culture (other than <i>Clostridium difficile</i> testing) from this patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<p>o. [IF YOU ORDERED A BACTERIAL STOOL CULTURE FROM THE LAST PATIENT YOU SAW WITH DIARRHEA]</p> <p>What was the MOST important factor in your decision to order a culture? [CHECK ONLY ONE]</p> <div style="display: flex; flex-wrap: wrap; justify-content: space-between;"> <div><input type="checkbox"/> Duration</div> <div><input type="checkbox"/> Fever</div> <div><input type="checkbox"/> Bloody diarrhea</div> <div><input type="checkbox"/> Abdominal pain</div> <div><input type="checkbox"/> Dehydration</div> <div><input type="checkbox"/> AIDS</div> <div><input type="checkbox"/> Patient request</div> <div><input type="checkbox"/> Travel</div> <div><input type="checkbox"/> Outbreak associated</div> <div><input type="checkbox"/> Other</div> </div> <p>(list) _____</p> <p>Was the culture positive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p> <p>[IF YES] Which of the following organisms was isolated:</p> <div style="display: flex; flex-wrap: wrap; justify-content: space-between;"> <div><input type="checkbox"/> <i>Salmonella</i></div> <div><input type="checkbox"/> <i>Shigella</i></div> <div><input type="checkbox"/> <i>Campylobacter</i></div> <div><input type="checkbox"/> <i>E. coli</i> O157</div> <div><input type="checkbox"/> <i>Vibrio</i></div> <div><input type="checkbox"/> <i>Yersinia</i></div> <div><input type="checkbox"/> <i>Aeromonas</i></div> <div><input type="checkbox"/> <i>Plesiomonas</i></div> <div><input type="checkbox"/> Can't recall name of organism</div> <div><input type="checkbox"/> Other (list) _____</div> </div>	
<p>p. [IF YOU DID NOT ORDER A BACTERIAL STOOL CULTURE FROM THE LAST PATIENT YOUR SAW WITH DIARRHEA]</p> <p>What was the MOST important factor in your decision NOT to order a culture? [CHECK ONLY ONE]</p> <div style="display: flex; flex-wrap: wrap; justify-content: space-between;"> <div><input type="checkbox"/> Culture previously ordered</div> <div><input type="checkbox"/> No fever</div> <div><input type="checkbox"/> No bloody diarrhea</div> <div><input type="checkbox"/> No abdominal pain</div> <div><input type="checkbox"/> No dehydration</div> <div><input type="checkbox"/> Short duration</div> <div><input type="checkbox"/> Patient refusal</div> <div><input type="checkbox"/> Results would not alter treatment</div> <div><input type="checkbox"/> Not outbreak related</div> <div><input type="checkbox"/> No travel</div> <div><input type="checkbox"/> Cost</div> <div><input type="checkbox"/> Not likely to yield a pathogen</div> <div><input type="checkbox"/> Other</div> </div> <p>(list) _____</p>	

SECTION C Last patient you saw with bloody diarrhea

14. When did you see your most recent patient who had **bloody diarrhea**?

☐ ≤ 1 month ago ☐ >1 to ≤ 6 months ago ☐ > 6 months to ≤ 12 months ago ☐ >12 months ago

Did you order a bacterial stool culture on this patient? ☐ Yes ☐ No ☐ Don't know

[IF YES] Did you specifically ask the laboratory to culture for *E. coli* O157?

☐ Yes ☐ No, our lab routinely cultures for O157 ☐ No ☐ Don't know

SECTION D Bacterial stool cultures

15. When you order a routine bacterial stool culture, where is it tested? **[CHECK ALL THAT APPLY- if you check more than one box, please indicate the approximate percentage for each]**

☐ lab in your office.....%

☐ local hospital lab(s) (name of hospital.....).....%

(name of hospital.....).....%

☐ independent lab(s) (name of lab.....).....%

(name of lab.....).....%

☐ other (specify).%
☐ don't know

For the next question, please consider the laboratory to which you send **MOST** stools for bacterial culture.

16. When you order a routine bacterial stool culture, that is, you make no specific requests to the laboratory, which of the following bacterial pathogens do you think that laboratory **always** tests for? **Please answer YES, NO, or DON'T KNOW for each bacterial pathogen.**

<i>Salmonella</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<i>Campylobacter</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
<i>Shigella</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<i>Vibrios</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
<i>E. coli</i> O157	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<i>Yersinia</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know				

[IF YES to "Other", please list] _____

17. In the past 12 months, approximately how many bacterial stool cultures did you order?

☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ >10

SECTION E Stool testing for ova and parasites

18. When you order a routine stool examination for ova and parasites, where is it tested? **[CHECK ALL THAT APPLY- if you check more than one box, please indicate the approximate percentage for each]**

☐ lab in your office.....%

☐ local hospital lab(s) (name of hospital.....).....%

(name of hospital.....).....%

☐ independent lab(s) (name of lab.....).....%

(name of lab.....).....%

☐ other (specify).%
☐ don't know

For the next question, please consider the laboratory to which you send **MOST** stools for ova and parasite testing.

19. When you order a routine stool examination for ova and parasites, that is, you make no specific requests to the laboratory, which of the following diarrheal pathogens do you think that laboratory **always** tests for? **Please answer YES, NO, or DON'T KNOW for each choice.**

<i>Giardia</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<i>Cyclospora</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
<i>Entamoeba histolytica</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<i>Isospora</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
<i>Cryptosporidium</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<i>Microsporidia</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know

Other protozoa ☐ Yes ☐ No ☐ Don't know

[IF YES to "Other protozoa", please

list] _____

20. In the past 12 months, approximately how many stool examinations for ova and parasites did you order?

☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ >10

SECTION F Scenarios

21. A previously healthy 3-year-old child presents to your office with a 3-day history of non-bloody diarrhea that is not improving. The patient has no other symptoms and no other significant history or physical findings.

For each scenario, please answer YES, NO, or DON'T KNOW to question 1 and 2.

Additional Information	Question 1: Would YOU order a routine <u>bacterial stool culture</u> ...	Question 2: Would YOU order a <u>stool examination for ova and parasites</u> ...
a. on this patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
b. if this patient was in a developing country in the week before diarrhea onset?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
c. if this patient had a fever of 101° F and bloody diarrhea ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
d. if this patient attended daycare ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
e. if this patient had AIDS ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
f. if this patient had a fever of 101° F ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
g. if this patient had a 10 day history of non-bloody diarrhea with no fever ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
h. if this patient had bloody diarrhea but did not have fever ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

Thank you for completing this survey. Please return the survey in the enclosed envelope